TITLE 8. INDUSTRIAL RELATIONS
DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
CHAPTER 4.5. DIVISION OF WORKERS' COMPENSATION
SUBCHAPTER 1. ADMINISTRATIVE DIRECTOR -- ADMINISTRATIVE RULES
ARTICLE 5.5.1 UTILIZATION REVIEW STANDARDS

§ 9792.11 Investigation Procedures: Labor Code §4610 Utilization Review Violations

(a) To carry out the responsibilities mandated by Labor Code section 4610(i), the Administrative Director, or his or her designee, shall investigate the utilization review process of any employer, insurer or other entity subject to the provisions of section 4610**.** The investigation shall include but not be limited to review of the practices, files, documents and other records, whether electronic or paper, of the claims administrator and any other person responsible for utilization review processes.

(b) Notwithstanding Labor Code section 129 (a) through (d) and section 129.5 subdivisions (a) through (d) and sections 10105, 10106, 10106.1, 10107, 10107.1, 10108, 10110, 10111, 10111.1, 10111.2, and 10112 of Title 8 of the California Code of Regulations, the Administrative Director, or his or her designee, may conduct a utilization review process investigation pursuant to Labor Code section 4610, which may include but is not limited to an audit of files and other records.

(c) A utilization review investigation may, in the discretion of the Administrative Director, or his or her designee, be conducted as an independent investigation, or may be conducted concurrently with a Labor Code section 129 and 129.5 routine, target or full audit.

(d) Administrative penalties may be assessed for any failure to comply with Labor Code section 4610, or sections 9792.6 through 9792.10 of Title 8, California Code of Regulations.

(e) The Administrative Director, or his or her designee, may also utilize the provisions of Government Code sections 11180 through 11191 to carry out these responsibilities.

(f) This section shall apply to any Labor Code section 4610 utilization review investigation conducted on or after August 1, 2006 and to actions which occurred on or after August 1, 2006.

(g) The Administrative Director, or his or her designee, may conduct a utilization review investigation based on:

1) Factual information or a complaint containing facts, indicating the possible existence of a utilization review violation; or
2) By selection of any claims administrator by the Division as part of an audit pursuant to Labor Code section 129 or 129.5 from among the list of known claims adjusting locations.

(h) Notwithstanding the language within the audit regulations referring to investigations and/or audits pursuant to Labor Code sections 129 and 129.5, the following audit regulations may, in the discretion of the Administrative Director, or his or her designee, apply to investigations conducted pursuant to Labor Code section 4610: Title 8, California Code of Regulations, sections 10100.2; 10101, 10101.1; 10102; 10103.2; 10104; 10106.5; 10107(a), (b), (c)(2), (d), (e), (f), (g), (h), (i), (j), (k), (l), and (m); and 10109.

(i) Any claims administrator or other person performing utilization review services for an employer shall provide the Administrative Director, or his or her designee, the current legal name, address, and phone number of the employer, upon request.

(j) Within 5 calendar days of the request, any claims administrator or employer, or third party administrator, or other person performing utilization review services for an employer shall provide the Administrative Director, or his or her designee, from all source locations all records involving the utilization review process under investigation.

(k) For the purposes of assessing penalties, if the date or deadline to perform any act related to utilization review practices falls on a weekend or holiday, the act may be performed on the first business day after the weekend or holiday, except that the timelines in sections 9792.9(b) and 9792.9(e) of Title 8 of the California Code of Regulations shall only be extended as provided under section 9792.9(g) of that title.

(l) If the claims administrator or other person performing utilization review services for the employer does not record the date a document is received, it shall be deemed received on the same day as the latest date the sender wrote on the document for information conveyed by telephone or facsimile. Documents sent via US mail shall be deemed received no later than five calendar days after the latest date the sender wrote on the document.

(m) Upon initiating an investigation into an alleged violation pursuant to section 9792.12(a) of these regulations, the Administrative Director, or his or her designee, may provide the claims administrator or other entity subject to Labor Code section 4610 with a written description of the factual information or of the complaint containing factual information that has triggered the utilization review

investigation. The claims administrator or other entity shall have ten (10) business days upon receipt of the written description to provide a written response to the Administrative Director or his or her designee. After reviewing the written response, the Administrative Director, or his or her designee, shall either close the investigation without the assessment of penalties or conduct further investigation to determine whether to impose penalty assessments.

Authority: Sections 133, 4610, and 5307.3, Labor Code.
Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610, and 4614, Labor Code.

§ 9792.12 Penalty Schedule for Labor Code §4610 Utilization Review Violations

(a) Single Instance Penalties. Notwithstanding Labor Code section 129.5(c)(1) through (c)(3), the penalty for each failure to comply with the utilization review process required by Labor Code section 4610 and the applicable regulations is:

(1) A maximum of $50,000 for failure to establish a utilization review process, to file a utilization review plan and to maintain a utilization review process in compliance with Labor Code section 4610, including the failure to include all of the following required information:

(A) The name, medical license number, and current areas of certified specialty and practice, of the employed or designated medical director, who holds an unrestricted license to practice medicine in the state of California issued pursuant to section 2050 or section 2450 of the Business and Professions Code.

(B) A description of the process whereby requests for authorization are reviewed, and decisions on such requests are made, and a description of the process for handling expedited reviews.

(C) A description of the specific criteria utilized in the review and throughout the decision-making process, including treatment protocols or standards used in the process for both routine and non-routine reviews, and as otherwise required by section 9792.7 of Title 8 of the California Code of Regulations.

(D) A description of the qualifications and functions of the personnel involved in decision-making and implementation of the utilization review plan and process.

(E) A description, if applicable, of any prior authorization process in the utilization review plan or process.

(2) A maximum of $10,000 for failure to have as the medical director of the utilization review process a physician who holds an unrestricted license to practice medicine in the state of California issued pursuant to section 2050 or section 2450 of the Business and Professions Code.

(3) A maximum of $5,000 for a decision to modify or deny a request for authorization based on the opinion of a reviewer, whether the medical director, expert reviewer or reviewer, regarding a medical treatment, procedure, service or product that is outside of the scope of practice or professional competence of the reviewer who made the decision.

(4) A maximum of $5,000 if the request for authorization is modified or denied by a reviewer, whether the medical director, expert reviewer or reviewer, who fails to state the portion of the medical criteria or guidelines relied on that is relevant to the injured employee's condition and to the requested treatment, as well as the clinical reasons for the decision and the reviewer's conclusion regarding medical necessity.

(5) A maximum of $5,000 if the request for authorization is denied solely on the basis that the requested treatment is not addressed by ACOEM or, after a medical utilization schedule has been adopted pursuant to section 5307.27 of the Labor Code, on the sole basis that it is not addressed by that medical treatment utilization schedule, when the requesting physician has provided the specific clinical rationale for the requested treatment and has provided or referred to relevant page(s) of other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based.

(6) A maximum of $5,000 if a person other than a reviewer, expert reviewer or medical director, as defined in section 9792.6 of Title 8 of the California Code of Regulations, makes a decision to delay, modify or deny a treatment authorization request.

(7) A maximum of $5,000 for failing to respond to the request for authorization by the employee's physician.

(8) A maximum of $5,000 in the case of concurrent review, for denying authorization of or discontinuing medical care, prior to discussing with the requesting physician reasonable options for a care plan and making a good faith effort to agree on a care plan as required by Labor Code section 4610(g)(3)(B).

(9) A maximum of $5,000 for failing to authorize and to provide all medical treatment consistent with Labor Code section 5307.27 or the ACOEM practice guidelines until either the claim has been accepted, rejected or the dollar threshold in Labor Code section 5402(c) has been paid.

(10) A maximum of $1,000 for failure to file with the Administrative Director a complete and current copy of the utilization review plan or a letter in lieu of a utilization review plan as required by section 9792.7(c) of these regulations.

(b) Multiple Instance Penalties. For each group of violations as set forth below:

(1) For each instance in which an expedited review decision is requested and appropriate, for the failure to make a decision in a timely fashion, not in excess of 72 hours after receipt of the information reasonably necessary to make the determination:

(A) $200 for 10 or fewer violations;

(B) $800 for 11 to not more than 20 violations;

(C) $3,200 for 21 to not more than 40 violations;

(D) $6,400 for more than 40 violations.

(2) For each failure to notify the requesting physician, the provider of services or goods identified in the request for authorization, the injured employee, and his or her attorney, if any, that additional information is needed in order to make a decision in compliance with the timeframes contained in section 9792.9 of Title 8 of the California Code of regulations:

(A) $200 for 10 or fewer violations;

(B) $800 for 11 to not more than 20 violations;

(C) $3,200 for 21 to not more than 40 violations;

(D) $6,400 for more than 40 violations.

(3) For each denial of authorization on the basis of lack of information where the claims administrator fails to make contemporaneous documentation reflecting his or her request for the necessary reasonable information from the requesting physician, the provider of goods or services identified in the request for authorization, or other person having the information:

(A) For request for concurrent authorization:

(1) $200 for 10 or fewer violations;

(2) $800 for 11 to not more than 20 violations;

(3) $3,200 for 21 to not more than 40 violations;

(4) $6,400 for more than 40 violations.

(B) For requests for prospective authorization:

(1) $100 for 10 or fewer violations;

(2) $400 for 11 to not more than 20 violations;

(3) $1,600 for 21 to not more than 40 violations;

(4) $3,200 for more than 40 violations.

(C) For requests for retrospective authorization:

(1) $50 for 10 or fewer violations;

(2) $200 for 11 to not more than 20 violations;

(3) $800 for 21 to not more than 40 violations;

(4) $1600 for more than 40 violations.

(4) $500 for the claims administrator's failure to include one or more of the following items in the written decision modifying, delaying or denying authorization for medical services which is provided to the requesting physician, the provider of goods or services identified in the request for authorization, the injured worker, and his or her attorney, if any:

(A) The date on which the decision was made;

(B) A description of the specific course of treatment or the medical services for which authorization was requested;

(C) A specific description of the course of treatment and medical services approved, if any.

(D) A specific description of the course of treatment and each medical service delayed, modified or denied in whole or part.

(E) A clear and concise explanation of the reasons for the decision to delay, modify or deny each item requested.

(F) A description of the medical criteria or guidelines relied upon by the reviewer, whether the medical director, expert reviewer or reviewer, in making the decision and a copy of the relevant page(s) or section(s) of such guidelines or criteria.

(G) The clinical reasons provided by the reviewer, whether the medical director, expert reviewer or reviewer, regarding medical necessity.

(H) A clear statement that any dispute shall be resolved in accordance with the provisions of Labor Code section 4062 and that an objection to the utilization review decision must be communicated by the injured worker or the injured worker's attorney, if any, to the claims administrator in writing within 20 calendar days of receipt of the decision. It shall further state that the 20-day time limit may be extended for good cause or by mutual agreement of the parties. The letter shall further state the injured worker may file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance with sections 10136(b)(1), 10400, and 10408.

(I) The following mandatory language:

"If you want further information, you may contact the local DWC Information and Assistance office by calling [enter district Information & Assistance office telephone number closest to the injured worker] or you may receive recorded information by calling 1-800-736-7401.

"You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits."

(J) The name of the reviewer relied on to make the decision modifying, delaying or denying the requested treatment authorization, along with the reviewer's current license(s), area(s) of certified specialty, area(s) of practice, address, telephone number, and hours of availability.

(5) For prospective or concurrent review, for each failure of the claims administrator to make a decision within 5 working days from the date of receipt of the information necessary to make the determination, and in no event more than 14 calendar days from the date of the request for authorization of medical

services made by the employee's physician or by the provider of services or goods identified in the request for authorization:

(A) $200 for 10 or fewer violations;

(B) $800 for 11 to not more than 20 violations;

(C) $3,200 for 21 to not more than 40 violations;

(D) $6,400 for more than 40 violations.

(6) For prospective or concurrent review, for each failure of the claims administrator to communicate to the requesting physician the decision to approve the requested authorization within 24 hours of the decision, as required by Labor Code section 4610(g)(3)(A):

(A) $100 for 10 or fewer violations;

(B) $400 for 11 to not more than 20 violations;

(C) $1,600 for 21 to not more than 40 violations;

(D) $3,200 for more than 40 violations.

(7) For each failure of the claims administrator to send written communication of the decision to modify, delay or deny in whole or in part the requested medical services, to the requesting physician, the provider of goods or services identified in the request for authorization, to the injured employee, and to his her attorney, if any, within twenty four (24) hours of making the decision, for concurrent review, or within two business days for prospective review:

(A) $100 for 10 or fewer violations;

(B) $400 for 11 to not more than 20 violations;

(C) $1,600 for 21 to not more than 40 violations;

(D) $3,200 for more than 40 violations.

(8) For retrospective review, for each failure of the claims administrator to communicate a decision to the requesting physician, the provider of goods or services identified in the request for authorization, to the injured worker, and to his or her attorney, if any, within 30 calendar days of receipt of the information that is reasonably necessary to make the determination:

(A) $100 for 10 or fewer violations;

(B) $400 for 11 to not more than 20 violations;

(C) $1,600 for 21 to not more than 40 violations;

(D) $3,200 for more than 40 violations.

(9) For each failure by the claims administrator to provide written notice immediately to the requesting physician, to the injured employee, and to his or her attorney, if any, that a decision on the request for authorization cannot be made within fourteen (14) days for prospective and concurrent reviews, or within thirty (30) days for retrospective reviews for one of the reasons stated in Labor Code section 4610(g)(5):

(A) $100 for 10 or fewer violations;

(B) $400 for 11 to not more than 20 violations;

(C) $1,600 for 21 to not more than 40 violations;

(D) $3,200 for more than 40 violations.

(10) For each instance in which a claims administrator, in reliance on Labor Code section 4610(g)(5), delays making or communicating a timely decision or extends the time for decision pursuant to section 9792.9 of these regulations on a request for authorization for medical services, and the claims administrator cannot provide documentation showing one of the following events occurred prior to or at the time the claims administrator communicated this reason for delay under Labor Code section 4610(g)(5):

i) the claims administrator had not received all of the information reasonably necessary and requested;

ii) the employer or claims administrator has requested a consultation by an expert reviewer;

iii) the physician reviewer has requested an additional examination or test be performed

(A) $100 for 10 or fewer violations;

(B) $400 for 11 to not more than 20 violations;

(C) $1,600 for 21 to not more than 40 violations;

(D) $3,200 for more than 40 violations.

(11) For each instance in which the claims administrator communicates a written decision in reliance on Labor Code section 4610(g)(5) to delay or extend the time for making a decision on a request for authorization for medical services, but fails to state one or more of the following, as appropriate, to explain the delay:

i) specifying the information reasonably necessary and requested but not received;

ii) the name of the expert reviewer to be consulted;

iii) the additional test(s) or examination(s) to be performed;

iv) the anticipated date on which a decision will be made.

(A) $100 for 10 or fewer violations;

(B) $400 for 11 to not more than 20 violations;

(C) $1,600 for 21 to not more than 40 violations;

(D) $3,200 for more than 40 violations.

(12) Following a delay or extension of time in reliance on Labor Code section 4610(g)(5), for each failure to make a decision to approve, modify, delay or deny the requested for medical services within 5 working days for prospective or concurrent review or 30 calendar days for retrospective review :

(A) $200 for 10 or fewer violations;

(B) $800 for 11 to not more than 20 violations;

(C) $3,200 for 21 to not more than 40 violations;

(D) $6,400 for more than 40 violations.

(13) Following a delay or extension of time in reliance on Labor Code section 4610(g)(5), for each failure to communicate the decision in a timely manner to the requesting physician, the provider of goods or services identified in the request for authorization, the injured worker, and his or her attorney, if any:

(A) $200 for 10 or fewer violations;

(B) $800 for 11 to not more than 20 violations;

(C) $3,200 for 21 to not more than 40 violations;

(D) $6,400 for more than 40 violations.

(14) For each failure by the claims administrator to disclose or otherwise make available the Utilization Review criteria or guidelines to the public if requested as required by Labor Code section 4610, subdivision (f)(5):

(A) $100 for 10 or fewer violations;

(B) $400 for 11 to not more than 20 violations;

(C) $1,600 for 21 to not more than 40 violations;

(D) $3,200 for more than 40 violations.

Authority: Sections 133, 4610, and 5307.3, Labor Code.
Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610, and 4614, Labor Code.

§ 9792.13 Assessment of Administrative Penalties – Penalty Adjustment Factors.

(a) In cases that the Administrative Director deems appropriate, the Administrative Director, or his or her designee, may adjust a penalty imposed under section 9792.12 after considering each of these factors:

(1) The medical consequences or gravity of the violation(s);

(2) The good faith of the employer, insurer or other entity subject to Labor Code section 4610;

(3) The history of previous penalties for violations of Labor Code section 4610 or these regulations;

(4) The number and type of the violations;

(5) The size of the claims adjusting location or other facility subject to section 4610 of the Labor Code;

(6) The time period covered by the investigation.

(b) For each multiple instance penalty assessed pursuant to section 9792.12(b) of these regulations, penalties shall be assessed by calculating the lesser of the amount of the penalty or three times the value of the sum of all requested medical services included in each group of violations resulting in a multiple instance penalty assessment.

(c) The Administrative Director, or his or her designee, may assess both an administrative penalty under Labor Code section 4610 and a civil penalty under subdivision (e) of Labor Code section 129.5 based on the same violation(s).

(d) Where an injured worker's or a requesting provider's refusal to cooperate in the utilization review process has prevented the claims administrator from determining whether there is a legal obligation to perform an act, the Administrative Director, or his or her designee, may forego a penalty assessment for any related act or omission.

(e) Nothing in these regulations shall bar the assessment of a separate civil penalty under Labor Code section 129.5(e).

Authority: Sections 133, 4610, and 5307.3, Labor Code.
Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610, and 4614, Labor Code.

§ 9792.14 Liability for Penalty Assessments.

(a) If more than one claims administrator or other entity subject to Labor Code section 4610 has been responsible for a claim file, utilization review file or other file that is being investigated or audited, penalties may be assessed against each such entity for the violation(s) that occurred during the time each such entity had responsibility for the file or for the utilization review process.

(b) The claims administrator or other entity subject to Labor Code section 4610 is liable for all penalty assessments, except that if the subject of the investigation or audit is acting as an agent, the agent is jointly and severally liable with the liable entity for all penalty assessments. This paragraph does not prohibit an agent and its principal from allocating the administrative penalty liability between them. Liability for civil penalties assessed pursuant to Labor Code section 129.5(e) for violations under Labor Code section 4610 or sections 9792.6 through 9792.10 of Title 8 of the California Code of Regulations shall not be allocated.

(c) Successor liability may be imposed on a claims administrator or other entity responsible for administering the utilization review process, that has merged with, consolidated, or otherwise continued the business of a corporation or other business entity that is a responsible party and failed to meet its obligations under Divisions 1 and 4 of the Labor Code or regulations of the Administrative Director. The surviving entity responsible for administering the utilization review process, shall assume and be liable for all the liabilities, obligations and penalties of the prior corporation or business entity. Successor liability will be imposed if there has been a substantial continuity of business operations and/or the new business uses the same or substantially the same work force.

Authority: Sections 133, 4610, and 5307.3, Labor Code.
Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610, and 4614, Labor Code.

§ 9792.15 Administrative Penalties Pursuant to Labor Code §4610 - Order to Show Cause, Notice of Hearing, Determination and Order, and Review Procedure.

(a) Pursuant to Labor Code section 4610(i), the Administrative Director shall issue an Order to Show Cause Re: Assessment of Administrative Penalty and Notice of Hearing when the Administrative Director, or his or her designee (the investigating unit of the Division of Workers' Compensation), has reason to believe that an employer, insurer or other entity subject to Labor Code section 4610 has failed to meet any of the requirements of this section or of any regulation adopted by the Administrative Director pursuant to the authority of section 4610.

(b) The order shall be in writing and shall contain all of the following:

(1) Notice that an administrative penalty may be assessed;

(2) The basis for the assessment, including a statement of the alleged violations and the amount of each proposed penalty;

(3) Notice of the date, time and place of a hearing. Continuances will not be allowed without a showing of good cause.

(c) The order shall be served personally or by registered or certified mail.

(d) Within five (5) business days of receipt of an Order to Show Cause re: Assessment of Administrative Penalties, the claims administrator, or other entity responsible for performing utilization review processes for the employer, shall serve by certified mail a complete copy of the Order on the employer, if different than the claims administrator.

(e) Within 30 calendar days after the date of service of the Order to Show Cause Re Assessment of Administrative Penalties, the employer, insurer or other entity may pay the assessed administrative penalties or file, as the respondent, with the Administrative Director an answer, in which the respondent may:

(1) Admit or deny in whole or in part any of the allegations set forth in the Order to Show Cause;

(2) Contest the amount of any or all proposed administrative penalties;

(3) Contest the existence of any or all of the alleged violations;

(4) Set forth any affirmative and other defenses;

(5) Set forth the legal and factual bases for each defense. Any allegation and proposed penalty stated in the Order to Show Cause that is not appealed shall be paid within thirty (30) calendar days after the date of service of the Order to Show Cause.

(f) Failure to timely file an answer shall constitute a waiver of the respondent's right to an evidentiary hearing. Unless set forth in the answer, all defenses to the Order to Show cause shall be deemed waived. If the answer is not timely filed, within ten (10) days of the date for filing the answer, the respondent may file a written request for leave to file an answer. The respondent may also file a written request for leave to assert additional defenses, which the Administrative Director may grant upon a showing of good cause.

(g) The answer shall be in writing signed by, or on behalf of, the employer, insurer or other entity subject to Labor Codes section 4610, and shall state the respondent's mailing address. It need not be verified or follow any particular form. In the event the respondent is not the employer, the employer's address shall be provided and the employer shall be included on the proof of service.

(1) The respondent must file the original and one copy of the answer on the Administrative Director and concurrently serve one copy of the answer on the investigating unit of the Division of Workers Compensation (designated by the Administrative Director). The original and all copies of any filings required by this section shall have a proof of service attached.

(h) At any time before the hearing, the Administrative Director may file or permit the filing of an amended complaint or supplemental Order to Show Cause. All parties shall be notified thereof. If the amended complaint or supplemental Order to Show Cause presents new charges, the Administrative Director shall afford the respondent a reasonable opportunity to prepare its defense, and the respondent shall be entitled to file an amended answer.

(i) At the Administrative Director's discretion, the Administrative Director may proceed with an informal pre-hearing conference with the respondent in an effort to resolve the contested matters. If any or all of the charges or proposed penalties in the Order to Show Cause, the amended Order or the supplemental Order remain contested, those contested matters shall proceed to an evidentiary hearing.

(j) Whenever the Administrative Director's Order to Show Cause has been contested, the Administrative Director may designate a hearing officer to preside over the hearing. The Administrative Director's, and any designated hearing officer's, authority includes, but is not limited to: conducting a prehearing settlement conference; setting the date for an evidentiary hearing and any continuances; issuing subpoenas for the attendance of any person residing anywhere within the state as a witness or party at any pre-hearing conference and hearing; issuing subpoenas duces tecum for the production of documents and things at the hearing; presiding at the hearings; administering oaths or affirmations and certifying official acts; ruling on objections and motions; issuing prehearing orders; and preparing a Recommended Determination and Opinion based on the hearing.

(k) The Administrative Director, or the designated hearing officer, shall set the time and place for any prehearing conference on the contested matters in the Order to Show Cause, and shall give reasonable written notice to all parties.

(l) The prehearing conference may address one or more of the following matters:

(1) Exploration of settlement possibilities;

(2) Preparation of stipulations;

(3) Clarification of issues;

(4) Rulings on identity and limitation of the number of witnesses;

(5) Objections to proffers of evidence;

(6) Order of presentation of evidence and cross-examination;

(7) Rulings regarding issuance of subpoenas and protective orders;

(8) Schedules for the submission of written briefs and schedules for the commencement and conduct of the hearing;

(9) Any other matters as shall promote the orderly and prompt conduct of the hearing.

(m) The Administrative Director, or the designated hearing officer, shall issue a prehearing order incorporating the matters determined at the prehearing conference. The Administrative Director, or the designated hearing officer, may direct one or more of the parties to prepare the prehearing order.

(n) Not less than 30 calendar days prior to the date of the evidentiary hearing, the respondent shall file and serve the original and one copy of a written statement with the Administrative Director, or the designated hearing officer, specifying the legal and factual bases for its answer and each defense, listing all witnesses the respondent intends to call to testify at the hearing, and appending copies of all documents and other evidence the respondent intends to introduce into evidence at the hearing. A copy of the written statement and its attachments shall also concurrently be served on the investigating unit of the Division of Workers' Compensation. If the written statement and supporting evidence are not timely filed and served, the Administrative Director, or the designated hearing officer, shall dismiss the answer and issue a written Determination based on the evidence provided by the investigating unit of the Division of Workers' Compensation. Within ten (10) calendar days of the date for filing the written statement and supporting evidence, the respondent may file a written request for leave to file a written statement and supporting evidence. The Administrative Director, or the designate hearing officer, may grant the request, upon a showing of good cause. If leave is granted, the written statement and supporting evidence must be filed and served no later than ten (10) calendar days prior to the date of the hearing.

(o) Oral testimony shall be taken only on oath or affirmation.

(p)(1) Each party shall have these rights: to call and examine witnesses, to introduce exhibits; to cross-examine opposing witnesses on any matter relevant to the issues even though that matter was not covered in the direct examination; to impeach any witness regardless of which party first called him or her to testify; and to rebut the evidence.

(2) In the absence of a contrary order by the Administrative Director, or the designated hearing officer, the investigating unit of the Division of Workers' Compensation shall present evidence first.

(3) The hearing need not be conducted according to the technical rules relating to evidence and witnesses, except as hereinafter provided. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of the evidence over objection in civil actions.

(4) Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions. An objection is timely if made before submission of the case to the Administrative Director, or to the designated hearing officer.

(q) The written affidavit or declaration of any witness may be offered and shall be received into evidence provided that (i) the witness was listed in the written statement pursuant to section 9792.13(m);, (ii) the statement is made by affidavit or by declaration under penalty of perjury, (iii) copies of the statement have been delivered to all opposing parties at least 20 days prior to the hearing, and (iv) no opposing party has, at least 10 days before the hearing, delivered to the proponent of the evidence a written demand that the witness be produced in person to testify at the hearing. The Administrative Director, or the designated hearing officer, shall disregard any portion of the statement received pursuant to this regulation that would be inadmissible if the witness were testifying in person, but the inclusion of inadmissible matter does not render the entire statement inadmissible.

(r) The Administrative Director, or the designated hearing officer, shall issue a written Recommended Determination and Order Assessing Penalty, if any, including a statement of the basis for the Determination and each penalty assessed, within 60 days of the date the case was submitted for decision, which shall be served on all parties. This requirement is directory and not jurisdictional.

(s) The Administrative Director shall have sixty (60) calendar days to adopt or modify the Determination and Order Assessing Penalty issued by the designated hearing officer. In the event the Recommended Determination and Order of the designated hearing officer is modified, the Administrative Director shall include a statement of the basis for the Final Determination and Order Assessing Penalty.

(t) The Final Determination and Order Assessing Penalty, if any, shall become the final for the purposes of review within twenty (20) days of the date it was served or deemed adopted, unless the aggrieved party files a timely Petition Appealing Determination of the Administrative Director. All findings and assessments in the Final Determination and Order Assessing Penalty not contested in the Petition Appealing Determination of the Administrative Director shall become final as though no petition was filed.

(u) At any time prior to the date the Final Determination and Order Assessing Penalty becomes final, the Administrative Director, or designated hearing officer, may correct the Final Determination and Order Assessing Penalty for clerical, mathematical or procedural error, or amend the Final Determination or Order Assessing Penalty for good cause.

(v) Penalties assessed in a Final Determination and Order Assessing Penalty shall be paid within thirty (30) calendar days of the date the Final Determination and Order became final. A timely filed Petition Appealing Determination of the Administrative Director shall toll the period for paying the penalty assessed for the item appealed.

(w) All appeals from any part or the entire Final Determination and Order Assessing Penalty shall be made in the form of a Petition Appealing Determination of the Administrative Director, in conformance with the requirements of chapter 7, part 4 of Division 4 of the Labor Code. Any such Petition Appealing Determination of the Administrative Director shall be filed at the Appeals Board in San Francisco (and not with any district office of the Workers' Compensation Appeals Board), in the same manner specified for petitions for reconsideration.

Authority: Sections 133, 4610, and 5307.3, Labor Code.
Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610, 4614, and 5300 Labor Code.